Louisiana Medicaid
Pain Management – Antimigraine Agents – Ergotamines

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request prior authorization for non-preferred ergotamine antimigraine agents.

Additional Point-of-Sale edits may apply.

*These agents may have **Black Box Warnings** and/or may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.*

Approval Criteria for Initial and Reauthorization Requests

- Recipient is 18 years of age or older on date of the request; **AND**
- Prescriber attests that the requested medication will not be prescribed for chronic daily administration and will not exceed the recommended dosage per prescribing information; **AND**
- Previous use of **TWO** preferred triptan antimigraine agents- **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least **TWO** preferred triptans; **OR**
    - The recipient has had an *intolerable side effect* to at least **TWO** preferred triptans; **OR**
    - The recipient has *documented contraindication(s)* to **ALL** preferred triptans that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred triptan that is appropriate* to use for the condition being treated; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Duration of initial and reauthorization approval: 12 months

References

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; https://www.clinicalkey.com/pharmacology/

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. Pharmacotherapy: A Pathophysiologic Approach, 10e New York, NY: McGraw-Hill; https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

Peer C Tfelt-Hansen (2013) Triptans and ergot alkaloids in the acute treatment of migraine: similarities and differences, Expert Review of Neurotherapeutics, 13:9, 961-963, DOI:10.1586/14737175.2013.832851. https://doi.org/10.1586/14737175.2013.832851

Revision / Date	**Implementation Date**
Single PDL Implementation	May 2019
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